HEALTH INSURANCE PARTNERSHIP SECTION 125 PREMIUM ONLY PLANS

QUICK START GUIDE JULY 2010

This summary is a starting point for plan adoption, use and operation. Be sure to get legal advice on plan rules, design and implementation. This handbook can also be found on the Health Insurance Partnership's website at www.hip.hca.wa.gov.

HCA 90-308 (07/10)

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This handbook was prepared by Milliman in consultation with the Health Insurance Partnership.

INTRODUCTION

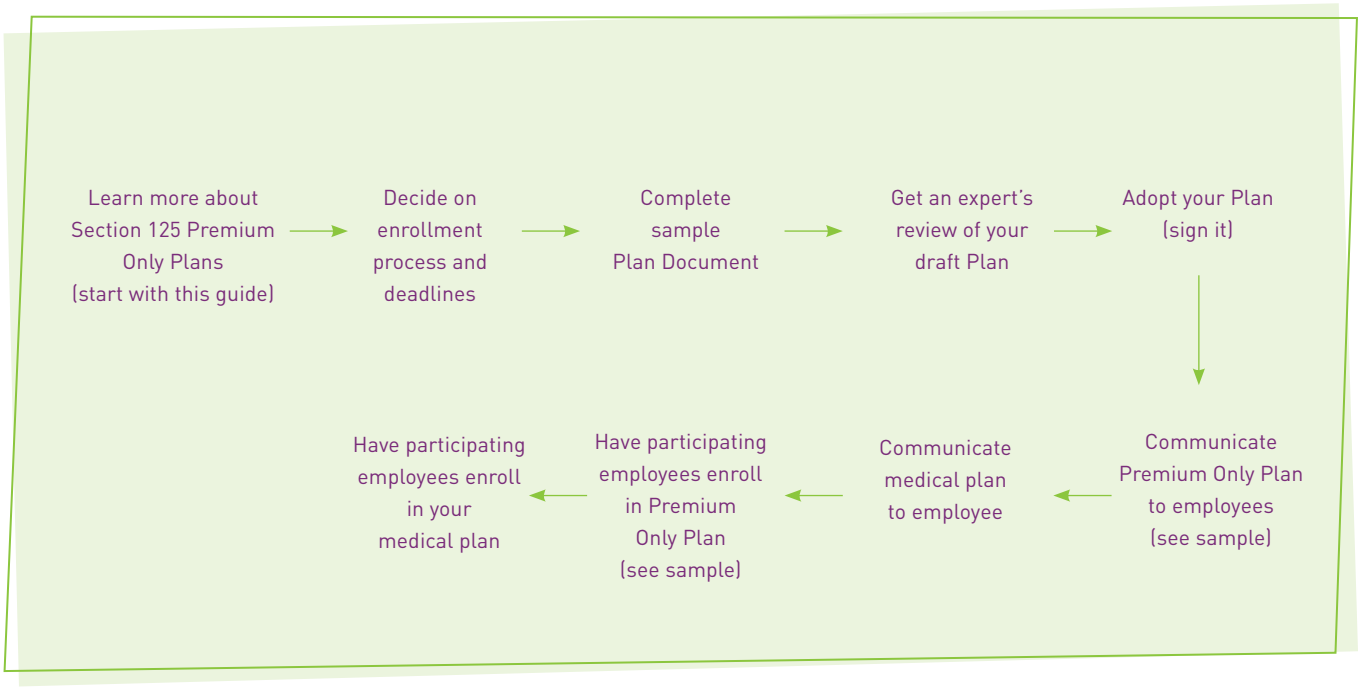
Welcome to the Health Insurance Partnership (HIP) Section 125 Premium Only Plan Quick Start Guide.

The HIP program provides health benefit plans to small employers in Washington State and their low-wage employees. Eligible employees may also receive a subsidy to help with their share of health benefit plan premiums.

A Section 125 Plan (also known as a "cafeteria plan") is a plan that allows you to offer certain benefits on a tax-advantaged basis. To participate in the HIP program, you must agree to have, at a minimum, a Section 125 Premium Only Plan which offers employees the option to have health benefit plan premiums deducted from their pay before taxes. Your Section 125 Plan can also cover health and dependent care flexible spending accounts, vision coverage, dental coverage, transportation benefits and other benefits. (Covering additional benefits is not included in this guide; you should work with your benefit adviser if you want a more comprehensive plan.) This guide will describe how to establish a Section 125 Premium Only Plan.

How This Guide Will Help You

This guide provides an overview of Section 125 Premium Only Plans and sample documents to help you get started. Your Section 125 Plan is separate from the medical plan you will contract for through the HIP program.



The HIP and the Health Care Authority (HCA) cannot provide legal advice or consulting services for establishing Section 125 Plans. Contact your benefit broker, legal adviser and/or tax adviser for review and details:

- → **Benefit Broker:** Your benefit broker can help you understand how a Section 125 Premium Only Plan works and can be valuable if you want to go beyond HIP requirements and establish a full Section 125 Plan.
- → **Payroll Service:** If you use a payroll service, they should know what a Section 125 Plan is and can help you with payroll details.
- → **Accountant:** Your accountant may be able to help you set up payroll deductions and W-2 reporting.
- → **IRS Regulations:** If you want to get into the technical details, visit the IRS website at www.irs.gov.

This guide doesn't address choosing a health benefit plan, enrolling in coverage or applying for a premium subsidy through the HIP. Visit the HIP website at www.hip.hca.wa.gov or contact your benefit broker for those details.

See Appendix A for a helpful implementation checklist.

We recommend your legal counsel review your Section 125 Plan document. Any information in this guide with respect to provisions of law or regulation is for informational use only and should not be relied upon without consultation with competent plan counsel qualified in employee benefit law.

SECTION 125 PREMIUM ONLY PLAN TAX ADVANTAGES

A Section 125 Premium Only Plan is authorized by Section 125 of the IRS code; you may know it as a "cafeteria plan." A Premium Only Plan helps employees pay for health benefit plans with a pretax deduction, reducing both the employee's and the employer's tax burden. Under a Premium Only Plan, an employee has 2 choices:

Because this is an IRS-approved method for saving on taxes, it comes with rules, as explained throughout this guide.

→ Elect to participate in the Premium Only Plan and pay for the employer-sponsored health benefit plan premium before taxes are withheld.

→ Decline participation and pay for the employer-sponsored benefit plan premiums after taxes are withheld, keeping all wages as taxable income.

"Pretax deduction" means subtracting premiums from the employee's gross pay before calculating federal income tax, Social Security/Medicare (Federal Insurance Contributions Act – FICA) and Federal Unemployment Tax Act (FUTA).

The following examples show how using a Section 125 Premium Only Plan can benefit you and your employees. (Of course, your premiums and salary amounts may differ.)

Weekly Pay Example

This assumes the employee:

→ Is in the 15% tax bracket
→ Files as married with 4 dependents for federal income tax
→ Pays $50 a week to cover self and family under an HIP-designated health benefit plan.

Weekly pay example	Without a Premium Only Plan	With a Premium Only Plan
Gross wage for **weekly** earnings	$ 600.00	$ 600.00
Pretax health insurance premium	$ 0.00	$ 50.00
Taxable income	$ 600.00	$ 550.00
FICA (.0765%)	$ 45.90	$ 42.08
Federal Income Tax	$ 5.48	$ .48
After-tax health insurance premium	$ 50.00	$ 0.00
Take home pay	**$ 498.62**	**$ 504.77**

This employee's tax savings is $8.82 a week, or $458.64 a year. Apply this savings to the premium and the employee's plan cost is $41.18 a week. In addition, you save $3.82 a week on this employee's FICA tax match, or $198.64 a year. (FUTA is not calculated for this example.)

Biweekly Pay Example

If you pay employees every 2 weeks, the impact of a $100 pretax deduction would be:

Biweekly pay example	Without a Premium Only Plan	With a Premium Only Plan
Gross wage for **biweekly** earnings	$ 1,200.00	$ 1,200.00
Pretax health insurance premium	$ 0.00	$ 100.00
Taxable income	$ 1,200.00	$ 1,100.00
FICA (.0765%)	$ 91.80	$ 84.15
Federal Income Tax	$ 10.96	$ .96
After-tax health insurance premium	$ 100.00	$ 0.00
Take home pay	**$ 997.24**	**$ 1,014.89**

The employee's tax savings is $17.65 every 2 weeks, or $458.90 a year. Apply this savings to the premium and the employee's plan cost is $82.35 each pay period. In addition, you save $7.65 every 2 weeks on this employee's FICA tax match, or $198.90 a year.

ESTABLISHING THE PLAN

This guide will help you understand IRS rules for setting up a Section 125 Premium Only Plan.

Overview:

Establish a Section 125 Premium Only Plan.
Complete the sample Plan Document in Appendix B. This is the legal document that describes your plan.

1. Adopt the Plan.
You must formally adopt the Section 125 Premium Only Plan before it takes effect. (See Appendix C for a sample Plan Adoption Agreement.) As the plan sponsor, you must sign the plan agreement before taking pretax deductions from an employee's paycheck. Otherwise, the plan does not legally exist, which can lead to serious tax consequences for you and your employees. Anyone with authority to adopt the plan (as determined by governing documents such as bylaws, corporate resolutions, job descriptions, etc.) may sign the adoption agreement and anyone may witness the signing. Once adopted, you must keep all Plan Documents as well as any changes with your records and make them available for inspection upon request by government agencies, plan participants, etc.

2. Communicate the plan to employees.
All eligible employees need to know how the plan operates and how it affects them, as well as eligibility and enrollment procedures. A sample Notice to Employees is in Appendix D.

3. Have participating employees sign an agreement.
Employees who wish to participate in the plan must complete and sign an enrollment form. You must keep records of their agreement for your payroll purposes. A sample pay deduction/enrollment form is in Appendix E.

4. Decide on enrollment process and deadlines.
IRS rules require employees to maintain their elections for the year, with specific exceptions. The plan election typically happens at the same time the employee elects the health benefit plan. See Enrollment Opportunities for details.

Once you establish, adopt and communicate the Section 125 Premium Only Plan, employees need to enroll by completing an agreement.

Decisions

You'll need to make several decisions about your health benefit plan, which will also affect your Section 125 Premium Only Plan.

Eligible Classes of Employees

As the employer, you determine employee eligibility and enrollment criteria for your sponsored health benefit plan. Generally, eligibility rules for a Section 125 Premium Only Plan follow the health benefit plan eligibility rules, but there can be exceptions.

For example, a key or highly compensated employee (as defined by the IRS) may not be eligible to participate in the Section 125 Premium Only Plan, but may still be eligible for the health benefit plan. This exclusion may apply to you, your spouse or other family members who work for you. In addition, your health plan may cover dependents who are not eligible for the Section 125 Premium Only Plan. For more information visit www.irs.gov.

Decisions such as who is eligible and how benefits are offered, must be reflected in the Plan Document and all communication materials.

Plan Year

You decide when the Section 125 Premium Only Plan is effective; it may differ from the health benefit plan effective date. First confirm with your health benefit plan agent when the health benefit plan rates adjust each year; this will help determine the Section 125 Premium Only Plan year, which runs for 12 months. The first plan year can be short (less than 12 months) if that makes business sense. For example, you might have a short plan year if you start the health plan June 1 but rates adjust each January 1. In this situation, the first Section 125 Premium Only Plan year would run from June 1-December 31, then from January 1-December 31.

Deduction Frequency

You'll determine how often you deduct premiums from employee paychecks. Deductions typically occur in conjunction with employee payroll. Check with your benefit adviser or payroll service provider to calculate the correct amounts for weekly or biweekly deductions. (It's not as simple as dividing the monthly premium by 4 or 2.) Be sure this frequency is in the Section 125 Premium Only Plan Document.

Reasons for Mid-Year Election Changes

Once you implement the Section 125 Premium Only Plan, certain rules control when employees can make changes. See Enrollment Opportunities for details.

Ongoing Elections

As described in the Enrollment Opportunities section of this guide, each year you will conduct an annual enrollment. Your Section 125 Premium Only Plan Document and employee communications must describe the enrollment process for your plan. For example, you may require employees to make an affirmative election to participate every year, even if they aren't making any health benefit changes. Or you can default to have the election continue unless an employee does make any changes (called an Evergreen or rolling election). Your Section 125 Premium Only Plan Document and annual enrollment materials must explain this.

Meeting Section 125 Requirements

As an employer and fiduciary, you have certain responsibilities for the implementation, operation and maintenance of the Section 125 Premium Only Plan. Generally, you must ensure the plan is run efficiently, is cost-effective and is fair to all eligible employees.

Consistent plan administration is critical to maintaining the Section 125 Premium Only Plan's tax-favored status. For example, if you make exceptions for any one employee, the plan could become invalid and this would have adverse tax consequences for you and your employees in an IRS audit.

Record Retention

Once you formally adopt your Section 125 Premium Only Plan, keep the Adoption Agreement and all other plan documents in your files. Any plan changes must be adopted before they're effective (you cannot make them retroactive except in special cases permitted by the IRS), and keep records of those changes.

Have these records available for inspection in case of an audit, questions or litigation.

Your plan records need to show valid adoption before you started pretax deductions, along with any plan changes and all administrative rules and procedures.

Employee Communication

The plan must be communicated in writing to all eligible current employees and new hires, with a reminder at each annual enrollment, including:

- → When they can enroll in or drop participation in the Section 125 Premium Only Plan
- → Statement that their pretax election is irrevocable for an entire year, except under certain circumstances
- → Which situations allow a mid-year election change and what documents are required
- → Potential impact of the pretax election on Social Security or any other benefit based on compensation.

You must keep copies of Section 125 Premium Only Plan communication with documented decisions such as mid-year changes, enrollment, etc.

You may also want to distribute the Certificates of Coverage (e.g., benefit books) to employees at the same time so they have information about the health benefit plan provisions.

Staying Current

You must keep your plan up to date and in compliance with the latest state and federal requirements.

Discrimination Testing

You may qualify for a Simple Cafeteria Plan as allowed for in the Patient Protection and Accountability Care Act (PPACA, also known as health care reform), which may waive the requirement for discrimination testing. Please consult your benefit broker for more details on how this provision may apply to your plan.

The IRS and federal Department of Labor (DOL) require that you test your Section 125 Premium Only Plan once a year to determine if eligibility or benefits discriminate in favor of highly compensated employees. These agencies can impose fines and penalties or disqualify your plans if you don't complete the test each year.

Federal regulations explain how and when the test must be performed. Keep the test results so you can prove it was conducted and that your plan passed in case of an audit. Your benefit broker or payroll service can assist you with the testing requirements.

The State of Washington will not perform this test on your behalf.

Audits

Both the IRS and DOL may examine your files as fiduciary of the plan. Take these audits seriously. (The State of Washington cannot assist if your plan is audited.)

EMPLOYEE CONTRIBUTIONS

Before you offer the Section 125 Premium Only Plan and start deducting pretax contributions, make sure you understand the rules summarized below.

Eligible Employees

You may offer the plan to, and make pretax deductions for:

- → Current common law employees who also meet eligibility requirements for your health benefit plan
- → Legal nonresident aliens receiving a U.S. source of income
- → Full-time insurance agents who are statutory employees
- → Former common-law employees (generally applies in a severance situation where benefits are continued as part of the severance package).

Ineligible Employees

The following workers are not eligible:

- → Self-employed individuals
- → A more-than-2% shareholder of an S Corporation (this includes spouses or children of the shareholder)
- → A partner in a general partnership or limited partnership.

Employees, not spouses, must elect their own health benefit plan and any coverage for other eligible dependents.

Eligible Dependents

Employees may make pretax deductions for dependents who meet the eligibility requirements under the health benefit plan if the dependent is also:

- → The employee's child, stepchild, legal foster child, legally adopted child or child placed for adoption who is under age 27 (check with your health plan provider regarding the rules for continuing adult children coverage)
- → The employee's legal spouse of the opposite sex, or
- → An individual who qualifies as the employee's dependent for federal tax purposes.

Employees cannot make pretax deductions for dependents who do not meet one of the requirements above. It is the employee's responsibility to ensure that his or her dependents meet the tax requirements. You should refer employees who have questions to their tax advisor.

Imputed Income

There are tax consequences for covering an individual who is not a spouse or other eligible dependent. For example, though you may allow domestic partners to be covered by the health benefit plan, they generally are not IRS-eligible dependents. This means the employee may not pay for the domestic partner's health benefit plan with pretax dollars under the Section 125 Premium Only Plan – and any employer contribution for a domestic partner's health benefit plan is considered imputed income to the employee. Imputed income is added to the employee's paycheck as taxable income. As the employer, you are responsible for any matching FICA and FUTA taxes. Check with your benefit adviser if you offer a health benefit plan to domestic partners or other individuals who are not IRS-eligible dependents.

No Retroactive Adjustments

You cannot allow an employee to add a health benefit plan for an earlier date and pay the back premium with pretax dollars on the next paycheck. The employee must pay any premium due from the retroactive date until the date the enrollment request is completed and approved with after-tax dollars. There are two exceptions to this rule:

- For a new hire, where there is a very short or no waiting period, the employee may not have time to make the election before it is effective. The IRS will allow the premium to be taken from the next paycheck. This exception applies only to new hires, not to rehires or to employees who move to a benefit-eligible position. The new hire must make the election within 30 calendar days of the hire date.

- The HIPAA special enrollment provision for newborns and newly adopted children allows a health benefit plan to be effective from the date of birth or date the child was placed for adoption. Any additional premium due for the period before the employee reports the event can be taken from the next paycheck after the enrollment request is approved.

No other mid-year election provisions allow for this retroactive pretax deduction.

Payroll Deductions

All pretax activity must be reported on each employee's W-2(s). Your payroll service, tax adviser or accountant may help set up your payroll system.

ENROLLMENT OPPORTUNITIES

You and your employees need to know that Section 125 Premium Only Plan coverage can only be elected at certain times.

New and Rehired Employees

An employee may enroll as of the date of hire or the first day of work, as stated in your Section 125 plan document. Typically, enrollment documents must be completed and returned to you within 30 calendar days of the date of employment. Benefits are effective the first day of the month following the completion of any waiting period, or the date of hire if there is no waiting period.

Employees rehired within 30 calendar days of termination must be reenrolled into the benefits in effect at their termination; they cannot elect a new set of benefits. Rehires may need to complete the waiting period (if they did not complete it prior to their termination).

The enrollment election is irrevocable for that plan year. The employee cannot change it until the next annual enrollment, or during the plan year if there is a qualifying change (as described below).

Newly Eligible

There may be a certain category of employees that you exclude from participating in the health benefit plan (e.g., temporary employees). Should an employee move from an excluded category to a benefit-eligible position, the employee has the right to elect benefits. The employee must complete a timely enrollment process (for example, within 30 calendar days of becoming eligible).

Annual Enrollment

Each year the insurer reviews your health benefit plan and determines if a rate increase and/or plan design change is necessary. Once you know of any changes, you must communicate them to your employees. You must also give employees an opportunity to add or drop dependents from a health benefit plan, elect a health benefit plan for the first time or drop a health benefit plan altogether. Enrollment decisions must be made before the beginning of the plan year when the new rates take effect. Employers typically hold a 2-week annual enrollment period 1-2 months before the new plan year begins.

You must specify which events your plan will recognize as reasons for an employee to make an election change – you'll need to decide how to handle this when you create your Section 125 Premium Only Plan document.

Mid-Year Changes (Change in Status)

The IRS has specific rules for when benefit election changes can be made during the plan year. In all cases, you must coordinate your Section 125 Premium Only Plan change in status events with your health benefit plan change in status events. In other words, a change is allowed under your Section 125 Premium Only Plan only if your health benefit plan also permits the change.

In most situations, a mid-year change must correspond with the life change that prompts it – for example, employees may drop an ex-spouse's health benefit plan when they get divorced, but they cannot drop their own. Talk with your legal counsel about the limited exceptions to this IRS consistency rule.

The key is to treat all of your employees the same way when enforcing the rules governing election changes. Employees must request the change within a specified time, usually 30 calendar days, consistent with the IRS minimum period. If a change is not reported within the time stated in your plan document, it cannot be allowed. You may require proof that the event occurred within the required timeline, such as a copy of a birth or marriage certificate. Requiring employees to complete a change in status form is the best way to ensure compliance; see Appendix F for a sample form.

Benefit election changes are effective going forward, except the effective date for a child born to an employee or adopted by an employee is the date of birth or date the child was placed in the employee's home for adoption.

Required by HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) includes the right to change health benefit plan enrollment elections during the year when there is a qualifying event. A Section 125 Premium Only Plan isn't technically required to allow these changes. But if it didn't, the employee would have to pay all or part of the premium for the changed election after-tax, and you as the employer would have to administer that process. For that reason, most Premium Only Plans allow these special enrollment changes.

- **Birth or Adoption of a Child:** HIPAA rules permit employees to add not only the new child, but themselves, a spouse and (if the health carrier allows) any previously non-covered children to the health benefit plan. The rules allow a corresponding change to the pretax deduction at the same time.

- **Loss of Coverage From Another Group Health Benefit Plan or Other Health Insurance:** Section 125 rules allow enrollment in your health benefit plan and pretax deductions under your Premium Only Plan if an eligible employee, spouse or other dependent was covered under another health benefit plan and then loses that coverage.

  If the employee had declined coverage for themselves, their spouse or other dependents because of other health coverage and then they lose that coverage due to loss of eligibility (including due to divorce, death, termination of employment or reduction in hours – or because employer contributions end) or the other coverage was under COBRA and it was exhausted, under HIPAA special enrollment rules they can enroll themselves, a spouse and (if the health carrier allows) any previously non-covered children to the health benefit plan as well. The rules allow a corresponding change to the pretax deduction at the same time.

  It does not apply if the employee or dependent lost coverage because they stopped paying for it.

- **Marriage:** An employee may add a new spouse and any other eligible dependents to the health benefit plan, with corresponding changes to the pretax deductions.

- **Medicaid/SCHIP:** An employee may enroll in the health benefit plan and/or add a spouse and any other eligible dependents if the employee or a dependent loses eligibility under either Medicaid or a state children's health insurance program (SCHIP). They may also enroll in the health benefit plan if the employee or a dependent becomes eligible for a state premium assistance subsidy from either Medicaid or SCHIP.

Allowed by the IRS

You are not required to allow mid-year election changes except for those situations required by HIPAA. However, if you do allow such changes, the IRS has specified the circumstances for such changes. The following events are allowable reasons for an employee to change an election mid-year. Your adoption agreement must reflect what changes you will allow and the time limits for reporting the change. The employee is responsible for notifying you within the timeline, so that pretax deductions can be changed. Remember that your list must coordinate with those allowed by your health carrier.

- **Marriage:** An employee may drop your health benefit plan and enroll under their spouse's health benefit plan, or add their new spouse to your plan. Pretax deductions may be changed accordingly.

- **Divorce:** An ex-spouse is not eligible under the health benefit plan and must be removed from the plan within the time your plan specifies, so that pretax deductions can be changed. An ex-spouse who is also your employee must enroll separately as an employee due to the divorce.

- **Death of Spouse or Child:** If a covered spouse or child dies, the employee can change their election to drop the person from the health benefit plan. The employee is responsible for letting you know within the time your plan specifies, so that pretax deductions can be changed.

- **Child No Longer Meets Health Benefit Plan Eligibility Requirements:** A child over age 26 may no longer be eligible under the health benefit plan. The employee is responsible for letting you know within the time your plan specifies, so that pretax deductions can be changed.

- **Loss of Certain Other Health Benefit Plans:** If the employee's spouse or child loses coverage under a public or government program such as the State Children Health Insurance Program (SCHIP) or Indian Health Services (IHS), the employee may enroll the dependent in your health benefit plan and change pretax deductions.

- **Entitlement to Medicare or Medicaid:** If an employee or dependent becomes a Medicare or Medicaid recipient, they can cancel coverage under your health benefit plan as well as pretax deductions. A recipient who loses coverage under either program can reenroll in both your health benefit plan and the Section 125 Premium Only Plan and make pretax deductions. Check with your health insurance carrier about the rules for Medicare enrollment. Many carriers do not terminate coverage when a person enrolls in Medicare and may not recognize this as a reason to stop coverage. If the carrier doesn't recognize this reason, the employee cannot change pretax deductions.

- **Judgments, Decrees and Orders:** This provision generally applies in a divorce or paternity determination. The judgment, decree or order will require a parent to provide health benefits for the child. You may also receive a qualified medical child support order or other order from the state requiring you to enroll the child for coverage. The judgment, decree or order may also allow the employee to discontinue the child's health benefit plan. Consider including this provision in your Section 125 Premium Only Plan so the employee can pay for that coverage pretax. Otherwise, the employee will have to pay for their share of the premium with after-tax deductions.

- **Child Now Meets Eligibility Requirements:** The child must be under the age of 27 and meet the health benefit plan eligibility criteria.

- **Change in Coverage for a Spouse or Child Under Another Employer Plan:** If a spouse or child drops coverage during another employer's annual enrollment period, the dependent may be allowed to enroll in your plan.

- **Family Medical Leave:** Washington has several state leave laws that may affect the employee's right to continue or change benefits, regardless of employer size. See www.lni.wa.gov/WorkplaceRights/LeaveBenefits/FamilyCare/LawsPolicies for more information.

- **Change in Residence:** This applies only if the employee moves out of the health benefit plan service area. Include this as an option in your Section 125 Premium Only Plan to accommodate an employee who moves outside of the service area.

- **Change in Employment Status:** This applies to employees who become eligible or ineligible for the health benefit plan.

- **Significant Cost Changes:** This applies if the carrier substantially increases or decreases health benefit plan premiums mid-year. The employee can either drop or enroll for coverage.

- **Significant Curtailment of Coverage:** In this case, if the employee otherwise continues to meet eligibility requirements, coverage may be dropped. (If it's the employee, the carrier will not let the dependent remain in the plan). This can happen if a large number of providers drop out of the network, a copay increases significantly mid-year, or the employer discontinues the health plan mid-year.

Not Allowed

Though not allowed, these are probably the most frequent requests you'll receive from employees who want to drop coverage in the health benefit plan. Annual enrollment is the next opportunity to change or drop the plan.

The following mid-year changes are not permitted:

- **Lack of Funds:** Once elected, the employee is obligated to continue coverage until the plan year ends.

You cannot terminate employment, then immediately rehire the employee, as a way to end coverage.

- **Wants to Drop the Coverage for a Reason Not Permitted by Your Plan:** The employee must remain enrolled in the health benefit plan until the plan year ends.

- **Doctor isn't in the Plan's Network:** Employees are responsible for making sure their doctors are in the provider network and will accept payment from the health benefit plan. Employees can verify this through provider directories or by calling the carrier or provider.

COBRA CONTINUATION COVERAGE & RESOURCES

To include pretax payments for COBRA coverage in your Section 125 Premium Only Plan, consult your benefit adviser.

If You Have Questions About...	Contact...
→ HIP subsidy → Enrollment requirements for a health benefit plan designated by HIP	Health Insurance Partnership 20021 120th Ave NE, Suite #200 Bothell, WA 98011 Toll Free: 800.377.0976 Local: 425.686.1370 Fax: 426.686.1395 **www.hip.hca.wa.gov**
→ Going beyond HIP requirements and establishing a full Section 125 Plan or clarifying a Premium Only Plan → Details on available health benefit plan options → Choosing a health benefit plan → Completing the health benefit plan application → Enrollment in the health benefit plan → Discrimination testing → Form 5500 filing	Your benefit adviser (agent, consultant, accountant or attorney)
→ Setting up pretax payroll deductions → FICA and FUTA → Imputed income → W-2 reporting	Your accountant and/or payroll service
→ Adopting your Section 125 Plan → Maintaining your Section 125 Plan → Employer responsibilities, including annual and initial notices to employees	An ERISA or benefit attorney
→ Federal tax rules and regulations	www.irs.gov
→ Federal employee benefits rules and regulations	www.dol.gov

GLOSSARY

Annual Enrollment

The time each year you allow employees to change pretax deductions for the next plan year for any reason (no requirement for a qualifying mid-year change). The annual enrollment period is generally held at least one month prior to when the health benefit plan renews each year.

Category of Employees

Employees may be categorized for employment and payroll purposes. For example, salaried employees, such as managers and supervisors, or hourly employees who work 40 hours a week. If you have temporary employees and do not offer them benefits, you need to classify this group as not eligible. If you will not exclude any employees from eligibility, you can just state that all employees are eligible to participate.

Common-Law Employee

According to the IRS, "Under common-law rules, anyone who performs services for you is your employee if you can control what will be done and how it will be done. This applies even when you give the employee freedom of action. What matters is that you have the right to control the details of how the services are performed." Go to www.irs.gov, the A-Z Index for Business, for details.

Discrimination Testing

Section 125 plan qualifies for a tax-favored status as long as the plan does not discriminate in favor of highly compensated employees (HCEs) and key employees when it comes to eligibility for the plan, contributions made on their behalf, and the benefits offered. The testing requirements are not easy to define as they can vary based on the plans you offer. In summary, your plan must meet the following requirements:

- → **Eligibility:** Among other requirements, your plan must have fair and reasonable eligibility requirements that permit at least 80% of employees not defined as highly compensated or key employees to participate in the plan.

- → **Contributions and Benefits Test (Utilization Test):** Your plan must offer the same or comparable benefits to all participants, including when benefits are available (probationary period), how much you contribute towards the plan, how much an employee must pay for the plan, and the opportunity to select a non-taxable benefit. Key employees cannot receive more than 25% of the benefit from the plan.

You must retain the results of your test in the event the IRS audits your plan.

More information about discrimination testing can be found at www.irs.gov.

ERISA

The federal Employee Retirement Income Security Act of 1984, as amended, which governs administration, supervision, and management of pension plans and welfare plans, including health benefit plans.

Evergreen Election Provision

The Section 125 pre-tax premium election is generally completed annually and confirms the employee's approval to continue the election with the new premium on a pre-tax basis. The Evergreen Election provision allows the current elections to automatically continue for the next plan year, even with the premium adjustment, without the employee completing a new election. The benefits selected in the previous plan year will continue for the new plan year, unless the employee actively makes changes to their election. In the event where there are changes to plans or previously elected options are no longer available, employees can be required to make a new election.

FICA

FICA is an acronym for Federal Insurance Contributions Act. The payroll tax is more commonly known as the Social Security and Medicare taxes. The employee and employer share in paying this tax based on an employee's earned income.

Fiduciary

Under ERISA, a person who:

- → Has discretionary authority or control over an employee benefit plan
- → Has any authority or control over plan assets
- → Renders investment advice for a fee
- → Has discretionary authority or responsibility in the plan administration.

Form 5500

Form 5500 Annual Return/Report of Employee Benefit Plan is the report filed each year with the Department of Labor (DOL) by pension and welfare benefit plans to report their financial condition, investments, and operations, as required under ERISA.

FUTA

FUTA is an acronym for Federal Unemployment Tax Act. FUTA, in conjunction with the state unemployment systems, provides unemployment benefits for workers who have lost their job. FUTA is paid only by the employer.

Highly Compensated Employee

According to the IRS, a highly compensated employee includes:

- An officer
- A shareholder who owns more than 5% of the voting power or value of all classes of the employer's stock
- An employee who is highly compensated based on the facts and circumstances
- A spouse or dependent of a person described above.

HIPAA

The federal Health Insurance Portability and Accountability Act of 1996, which includes coverage protections under health benefit plans that:

- Limit exclusions for preexisting conditions
- Prohibit discrimination against employees and dependents based on health status
- Allow a special opportunity to enroll in a new plan to individuals in certain circumstances.

HIPAA Special Enrollment Rights

HIPAA requires group health benefit plans to provide special enrollment opportunities as a result of certain losses of health benefit plan eligibility, eligibility for certain premium subsidies, and if a new spouse or dependent is acquired by marriage, birth, adoption or placement for adoption.

Mid-Year Changes

Employees can change pretax deductions during the plan year only if they have a qualifying life change, if that change affects their benefit eligibility and if your health benefit plan permits employees to change coverage based on the event.

Plan Administrator

A person or entity specifically designated by a health benefit plan's terms to administer the health benefit plan. If the plan does not make this a designation, the plan sponsor is generally recognized as the plan administrator. If a plan administrator is not designated and a plan sponsor cannot be identified, the administrator may be a person prescribed in regulations by the Secretary of Labor (source: Employee Benefits Security Administration, www.dol.gov/elaws/ebsa/health/4.asp).

Plan Sponsor

Generally, the employer, the employee organization (such as a union) or both that establishes or maintains a health benefit plan, including a group health benefit plan (source: Employee Benefits Security Administration, www.dol.gov/elaws/ebsa/health/4.asp).

Section 125 Premium Only Plan

A separate written employer plan (not the health benefit plan) maintained for employees that meets the specific requirements and regulations of Internal Revenue Code Section 125 and gives employees an opportunity to receive or pay for certain benefits on a pretax basis.

Simple Cafeteria Plan

The Patient Protection and Affordable Care Act (PPACA), also known as health care reform, offers employers a safe harbor option starting January 1, 2011. To qualify for the safe harbor option, and therefore not be required to test for discrimination, your plan must meet four (4) basic requirements as summarized below.

- → The employer must have employed, on average, 100 or less employees in the past two years.
- → All employees who worked at least 1,000 hours in the previous year must be eligible to participate in the plan (does not apply to excludable employees).
- → An employee that is eligible must be able to elect any qualified benefit under the plan (subject to terms and conditions to all employees).
- → The employer must make a true employer contribution for each employee that is not a key or highly compensated employee that is at least a) two percent of the employee's compensation for the plan year, or b) the lesser of six percent of the employee's compensation for the plan year or twice the employee's salary reduction (the employee's portion of the premium).

Your benefit broker or tax accountant may be able to assist you with determining if you qualify for the safe harbor option.

Waiting Period

The time an employee must wait, after the employee's hire date, before the health benefit plan election becomes effective.

FREQUENTLY ASKED QUESTIONS

What's the difference between a Section 125 Plan and a health benefit plan?

A health benefit plan provides medical coverage for covered employees. A Section 125 Plan allows you to deduct health benefit plan premiums pretax and may offer other pretax benefits.

What is a Section 125 Premium Only Plan?

A Section 125 Premium Only Plan allows employees to pay health benefit plan premiums pretax. If you want to expand your Section 125 Plan to include additional provisions such as flexible spending accounts (healthcare or dependent care), you should contact your benefit broker or benefit attorney for assistance.

What if I already have a Section 125 Plan in place?

If you have a Section 125 Plan (premium only or a more expanded plan) that allows you to deduct health benefit plan premiums pretax, you've already met that HIP requirement.

Can I enroll in the HIP without a Section 125 Plan?

No; Washington State law requires you to have a Section 125 Plan to participate in the HIP program.

What do I need to do?

To participate in the HIP program, you must establish a Section 125 Plan. Then, you will contract with a HIP participating carrier that has agreed to offer health benefit plan coverage through the HIP. See the Participant Handbook at www.hip.hca.wa.gov for details on your options and how to complete the process.

What happens if I cancel the health plan mid-year; must the pretax deductions continue through the end of the plan year?

For a Section 125 Premium Only Plan, this can be viewed as a significant curtailment of coverage to employees. This mid-year status change allows the employee to change their election mid-year and stop contributions. The employee contributions stop the first day of the month in which the health plan no longer exists.

Do I need to file a Form 5500?

Not for the Section 125 plan. However, since the premium you collect for the health benefit plan is paid to a third party and they pay the insurer after a subsidy from the HIP is applied, you are required to complete and file a Form 5500 for the health plan with the Department of Labor (DOL Reg. Section 2520.104-20(b)(2) and DOL Advisory Opinion 79-63A).

APPENDIX A

SAMPLE SECTION 125 PLAN IMPLEMENTATION CHECKLIST

APPENDIX A
SAMPLE SECTION 125 PLAN IMPLEMENTATION CHECKLIST

Participating in the HIP subsidy program requires the establishment of a Section 125 Plan – at a minimum, a Premium-Only Plan, which involves these steps:

- O Decide if any part of the plan's administration will be outsourced to a third party (for example, payroll reductions)
- O Prepare materials necessary to administer the plan:
  - O Plan Document
  - O Plan Adoption Agreement
  - O Election forms
  - O Election confirmations
- O Make decisions regarding mid-year election changes for allowable events
- O Have all documentation reviewed by legal counsel
- O Prepare enrollment communications
- O Obtain Certificates of Coverage from the carrier for distribution to employees (e.g., benefit books)
- O Modify business tax payment process to allow for reduction in FICA and FUTA taxes
- O Schedule nondiscrimination testing
- O Identify resources for ongoing advice and assistance.

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

APPENDIX B

SAMPLE PLAN DOCUMENT

APPENDIX B
SAMPLE PLAN DOCUMENT

[Company Name]

Section 125 Premium Only Plan

Plan Document

Effective

[Date]

TABLE OF CONTENTS

This document, together with the Adoption Agreement, is the Plan Document. If the Adoption Agreement is not attached, then the Plan Document is not complete.

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

Article 1. Introduction

1.1 Introduction

[Company] (Plan Sponsor) hereby establishes, effective _____, the [Company] Section 125 Premium Only Plan (Plan) to provide Eligible Employees the opportunity to pay for health benefit plan premiums elected under a separate Health Benefit Plan on a pretax basis. The Plan is intended to be a cafeteria plan under Internal Revenue Code Section 125 and the regulations there under.

Article 2. Eligibility and Participation Requirements

2.1 Eligibility and Participation

Eligible Employees are those categories of Employees identified as eligible in the Adoption Agreement. In order to participate in the Plan, an Eligible Employee must complete the waiting period specified in the Adoption Agreement and enroll in the Plan. Only Employees of the Company are eligible to participate in the Plan.

2.2 Enrollment and Elections

Eligible Employees must complete and submit an election form within the time specified in the Adoption Agreement or this section 2.2, as applicable, to enroll. If an Eligible Employee enrolls in a Health Benefit Plan but fails to timely enroll in this Plan, employee contributions required under the Health Benefit Plan shall be made on an after-tax basis. This section 2.2 shall not affect any eligibility or enrollment requirements or waiting periods under the Health Benefit Plan.

2.2.1 Initial Election

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

A new Employee who becomes eligible to participate during a plan year may elect to participate by filing an election form provided by the Plan Administrator within the time specified in the Adoption Agreement (the Initial Enrollment Period). An Employee who does not elect to participate within the time specified in the Adoption Agreement may not enroll until the next Open Enrollment Period or when a Change in Status Event occurs, as provided in the following sections.

2.2.2 Annual Election

The Plan Administrator shall establish an Open Enrollment Period each year during which Eligible Employees may make elections with respect to the following Plan Year. Eligible Employees must complete and return their election form before the deadline specified by the Plan Administrator in order to participate in the Plan for the following year, unless the Plan contains an Evergreen election provision as specified in the Adoption Agreement. If the Plan contains an Evergreen election provision, Eligible Employees who do not return an election form before the deadline specified by the Plan Administrator will be deemed to have elected to continue the election currently in force.

2.2.3 Election Changes

An election under the Plan is irrevocable for the Plan Year (or portion of a Plan Year) to which the election relates, except as otherwise provided in this section. An Eligible Employee may change his or her election during a Plan Year only upon the occurrence of (1) a Special Enrollment Event or (2) a Change in Status Event listed in Article 7 below and selected in the Adoption Agreement which is also a permitted change in status event under the Health Benefit Plan. Such changes must be made within the time period specified in the Adoption Agreement and must satisfy the "consistency rule" – that is, changes must be on account of and correspond with a Change in Status Event that affects eligibility for coverage under the Health Benefit Plan. No election change is permitted upon the occurrence of a Change in Status Event that does not affect eligibility for coverage. An Eligible Employee may change his or her election with respect to a future Plan Year as provided in subsection 2.2.2.

2.2.4 Changes to Elections by Plan Administrator

If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination or other requirement imposed by the Internal Revenue Code or any limitation on benefits provided to "key employees" as defined for purposes of Internal Revenue Code Section 125 and the regulations thereunder, the Plan Administrator shall take such action as deemed appropriate, under rules uniformly applicable to similarly situated employees, to assure compliance, including modifying elections by Employees without such Employees' consent.

If the cost of coverage under a Health Benefit Plan elected by an Employee increases or decreases during the Plan Year, the Plan Administrator shall make a corresponding change in the pretax compensation reductions of the Employee reflecting such increase or decrease.

2.2.5 Coverage Effective Dates

Coverage elected during the Initial Enrollment Period shall be effective as specified in the Adoption Agreement. Coverage elected during an Open Enrollment Period shall be effective on the first day of the calendar year after the end of the Open Enrollment Period. Coverage elected during a Special Enrollment Period occurring due to loss of other coverage, marriage, loss of eligibility for Medicaid or a state children's health insurance program (SCHIP) or becoming eligible for a state premium assistance subsidy through Medicaid or SCHIP shall be effective as specified in the Adoption Agreement. Coverage elected during a Special Enrollment Period because of the birth, adoption or placement for adoption of a Dependent shall be effective as of the date of birth, adoption, or placement for adoption. Coverage elected in connection with a Change in Status Event shall be effective as specified in the Adoption Agreement.

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

2.3 Termination of Participation

An Eligible Employee who has elected to participate in the Plan will cease to participate in the Plan upon the earlier of the termination of the Plan or the date the individual ceases to be an Eligible Employee (because of termination of employment for any reason, reduction of hours, or any other reason). If an Eligible Employee terminates employment for any reason and is rehired within 30 calendar days after the date of termination, he or she shall be reinstated to the same elections under this Plan as were in effect immediately prior to his or her termination. An Eligible Employee who is terminated and rehired more than 30 calendar days after termination shall be treated as a new Employee and may elect to participate as provided in subsection 2.2.1.

Article 3. Plan Benefits

3.1 Benefits Provided

The Plan provides the opportunity to pay the required employee contributions for health benefit plan premiums elected under a Health Benefit Plan for the Eligible Employee and/or his or her Spouse and/or Dependents on a pretax basis. If an Eligible Employee elects to participate in this Plan, contributions shall be deducted from his or her pay in approximately equal amounts each pay period. If an Eligible Employee elects not to participate in this Plan, contributions shall be paid on an after-tax basis outside this Plan. Contributions for health benefit plan premiums elected for individuals who are not the Eligible Employee's Spouse or Dependent may not be made under this Plan and must be made on an after-tax basis. The maximum amount of elective contributions under the Plan for a Participant is the maximum contribution required under the Health Benefit Plan for the coverage elected by the Participant under that Health Benefit Plan.

The required contributions for health benefit plan premiums, including the portion of such contribution to be paid by the Employee, are established under the Health Benefit Plan. The requirements for participating in the Health Benefit Plan, the types and amounts of health coverage available under the Health Benefit Plan, and all other terms of participation in and coverage under the Health Benefit Plan are established in the Health Benefit Plan. All claims for benefits under the Health Benefit Plan shall be subject to and governed by the terms of the Health Benefit Plan.

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

Article 4. Plan Administration

4.1 Plan Administration

The Plan is administered by [company] as Plan Administrator for all purposes. The [insert proper title] of [company] is the person who acts on behalf of the Company in performing its duties as Plan Administrator. [company] has agreed to indemnify the [insert proper title] for any liability that he or she incurs as a result of acting on behalf of the Company, unless such liability is due to his or her gross negligence or misconduct.

The Plan Administrator shall have duties and powers as necessary or appropriate to administer this Plan. The Plan Administrator has the discretionary and sole authority to interpret the Plan and to determine all matters under the Plan. Any determination of the Plan Administrator shall be conclusive and binding on all parties with an interest in such matter. The Plan Administrator may prescribe forms and procedures to be followed with respect to elections under the Plan. The Plan Administrator may also appoint and hire such individuals or entities as it deems necessary or advisable to assist in the administration of the Plan, including without limitation, legal counsel, consultants, third party administrators, or advisers.

4.2 Expenses

All reasonable expenses incurred in administering the Plan shall be borne by the Company.

4.3 Claims

Claims regarding eligibility and participation in the Plan or any other matter under the Plan, including without limitation, election changes, must be submitted to the Plan Administrator in writing within 30 calendar days of the event giving rise to the claim. If a claim is incomplete, the Plan Administrator will notify the claimant, describe the required information, and permit the claimant 45 calendar days from the date the notice is received to provide the required information.

If a claim is denied in whole or in part, the Plan Administrator will notify the claimant in writing within 30 calendar days after the date the Plan Administrator receives the claim, except that this 30-day period will be suspended for up to 45 calendar days during the time a request for additional information is pending as provided in the preceding sentence. If the Plan Administrator denies a claim in whole or in part, the Plan Administrator's written notification shall specify, in a manner calculated to be understood by the claimant, the reason for denial, the specific section or sections of the Plan upon which the denial is based, and an explanation of the claim review procedure specified in the Plan including applicable time limits.

If any additional material or information is required to process the claim, the denial shall describe such information and indicate why it is necessary. If the claimant is dissatisfied with the Plan Administrator's response, the claimant may request a full and fair review of the claim by the [company officer title] upon written request submitted by the claimant to the Plan Administrator within 60 calendar days after the claimant receives written notification that the claimant's claim has been denied. In connection with this review, the claimant is entitled to review pertinent documents upon request and submit in writing the claimant's views as to the issues. The [company officer title] shall act to deny or accept the claim within 60 calendar days after receipt of the claimant's written request for review unless special circumstances require the extension of this 60-day period.

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If extension is necessary, the [company officer title] shall provide the claimant with written notification of the extension before the expiration of the initial 60-day period. In all events, the [company officer title] shall act to deny or accept the claim within 120 calendar days of receipt of the claimant's written request for review. The action of the [company officer title] shall be in the form of a written notice to the claimant and its contents shall include all of the requirements for action on the original claim.

Article 5. Amendment or Termination of the Plan

5.1 Amendment or Termination

The Company intends to continue this Plan for an indefinite period of time. However, the Company, as Plan Sponsor, has the right to amend or terminate the Plan at any time by action of the Company's governing body. Any amendment will be made in writing and may only be effective prospectively after the later of the date the amendment is adopted by the Company or the effective date of the amendment, unless otherwise permitted by governing law.

Article 6. General Information About the Plan

6.1 No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between any individual and the Company to the effect that the individual will be employed for any specific period of time.

6.2 Governing Law

The Plan shall be construed and administered according to the laws of the State of Washington to the extent federal law does not apply.

Article 7. Change in Status Events (Mid-Year Election)

7.1 HIPAA Special Enrollment Rights

The occurrence of an event entitling an Eligible Employee (and/or his or her Dependents) to special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA).

7.2 Legal Marital Status

Change in the legal marital status of an Employee and a Spouse, including marriage, death of Spouse, and divorce. Legal separation and/or annulment are also included if such events result in loss of coverage under the Health Benefit Plan.

7.3 Number of Dependents

Change in the number of Dependents of the Employee, including birth, death, adoption, and placement for adoption.

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

7.4 Employment Status

Change in the employment status of an Employee, Spouse, or Dependent, including termination, hire, strike or lockout, beginning or ending an unpaid leave of absence (but special rules may apply if leave is FMLA-qualified leave), and change in worksite.

7.5 Dependent Satisfies or Ceases to Satisfy Eligibility Requirements

An event causing an Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage under the Health Benefit Plan on account of attainment of age, student status, employment or any similar circumstance.

7.6 Resident

Change in the place of residence of the Employee, a Spouse or Dependent.

7.7 Qualified Medical Child Support Order (QMCSO)

A judgment, decree or order resulting from a divorce, legal separation, annulment, or child custody order that requires health benefit coverage for the Employee's child or foster child who is the Employee's Dependent.

7.8 Entitlement to Medicare or Medicaid

An Employee, Spouse or Dependent becomes entitled to, or loses coverage under Medicare or Medicaid.

7.9 Significant Cost or Coverage Changes

→ The cost to an Employee for an option under the Health Benefit Plan significantly increases or decreases, or

→ Coverage (benefits and/or available services) under the Health Benefit Plan is significantly curtailed for the Employee or Spouse or Dependent (with or without a loss of coverage), or

→ A new coverage option is added or an existing coverage option is significantly improved under the Health Benefit Plan.

7.10 Loss of Coverage under Other Group Health Benefit Plan

The Employee, Spouse or Dependent loses coverage under any group health benefit coverage sponsored by a governmental or educational institution, such as the State Children's Health Insurance Program (SCHIP), a state health benefits risk pool, or a medical care program of an Indian tribal government, the Indian Health Service, or a tribal organization, or a foreign government group health benefit plan.

7.11 Change in Coverage under Another Employer Plan

Another employer plan permits a change described in sections 7.1 through 7.10 and the change under this Plan corresponds with that change, or the period of coverage under this Plan is different than the period of coverage under the other employer plan.

Article 8. Definitions

The following definitions shall apply throughout this Plan Document and the Adoption Agreement:

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

"Change in Status Event" means an event listed in Section 7 of this Plan Document and selected in the Adoption Agreement, the occurrence of which permits an Employee to make a mid-year change to his or her election under this Plan pursuant to subsection 2.2.3.

"Company" or "Employer" means [name of company].

"Dependent" means an eligible spouse or dependent under the terms of the Health Benefit Plan so long as such individual is also eligible for tax-free healthcare coverage.

"Eligible Employee" means an Employee who meets the eligibility requirements set forth in the Adoption Agreement.

"Employee" means an individual classified by [company] as an employee who is on Company's payroll but does not include a leased employee or an employee classified by Company as a temporary employee or independent contractor for the period during which the individual is classified as such, notwithstanding any subsequent reclassification or such individual by Company or any governmental agency or other third party. "Employee" also does not include a self-employed individual or a partner in a partnership, a sole proprietor, a director of a corporation who is not also an employee, or a 2% shareholder in a Subchapter S corporation.

"Health Benefit Plan" means a separate plan maintained by the Company for its Employees (and for spouses and dependents if so provided in such plan) providing medical benefits through a group health benefit plan or a group insurance policy.

"Initial Enrollment Period" means the period of time a newly-eligible Employee has to enroll in the Plan, as specified in the Adoption Agreement.

"Open Enrollment Period" means the annual period during which an Eligible Employee may choose to enroll in the Plan for the following year.

"Employee" means an Eligible Employee who has elected to participate in the Plan.

"Plan" means this [company] Section 125 Premium Only Plan.

"Plan Administrator" means [company].

"Plan Year" means the 12-month period specified as the Plan Year in the Adoption Agreement.

"Special Enrollment Event" means an event entitling an Eligible Employee (and/or his or her Dependents) to special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA).

"Special Enrollment Period" means the period following the occurrence of a Special Enrollment Event during which Eligible Employees may choose to enroll themselves (and Dependents) in the Plan, as specified in the Adoption Agreement.

"Spouse" means an individual of the opposite sex who is legally married to an Eligible Employee under applicable state law.

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

IN WITNESS WHEREOF, [company] has caused this Plan to be executed, effective as of

_____.

[company]

By: _____

Its: _____

Witness Signature: _____

APPENDIX C

SAMPLE PLAN ADOPTION AGREEMENT

APPENDIX C
SAMPLE PLAN ADOPTION AGREEMENT

Section 125 Premium Only Plan

General Information

1. Name of Plan:

_____

2. Employer's information:

_____

Employer

_____

Contact Person

_____

Address

_____

Telephone Number

_____

3. Employer's federal Employer Identification Number (EIN):

_____

4. Initial plan effective date: _____

5. Name and address of employer person designated as Agent for Service of Legal Process (if different from the contact person listed in 2):

_____

_____

6. Plan Year (start and end dates):

_____

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

Eligibility

7. Employees eligible to participate in the plan:

O All employees of the employer

O All full-time employees of the employer – those required to work _____ or more hours a week

O All part-time employees of the employer – those required to work at least _____ hours but less than _____ hours a week

O Other _____.

8. Employees not eligible to participate in the plan:

O Collectively bargained employees, unless their collective bargaining agreement specifically provides for participation

O Leased employees

O Other.

9. Waiting period, if any, which an employee must complete before being eligible to participate in the plan:

O Immediate eligibility

O 30 calendar days

O 60 calendar days

O 90 calendar days

O Other _____.

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

Enrollment

10. To enroll self and/or dependents when first eligible, an employee must enroll within:

O 30 calendar days following the date the employee satisfies eligibility requirements

O 31 calendar days following the date the employee satisfies eligibility requirements

O 60 calendar days following the date the employee satisfies eligibility requirements

O 90 calendar days following the date the employee satisfies eligibility requirements

O Other _____.

11. To enroll self and/or dependents upon loss of other coverage, marriage, birth, adoption or placement for adoption, an employee must enroll within:

O 30 calendar days following the special enrollment event

O 31 calendar days following the special enrollment event

O 60 calendar days following the special enrollment event

O 90 calendar days following the special enrollment event

O Other _____.

An employee/dependent also may enroll in the plan during an open enrollment period as stated in the plan document.

12. To enroll self and/or dependents upon loss of eligibility for Medicaid or a state children's health insurance program (SCHIP) or upon becoming eligible for a state premium assistance subsidy through Medicaid or SCHIP, an employee must enroll within:

O 60 calendar days following the special enrollment event

O 90 calendar days following the special enrollment event

O Other _____.

Effective Date of Coverage

13. Coverage of an employee who enrolls timely when first eligible as described above will be effective:

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

O As of the date the employee satisfies eligibility requirements.

O As of the date the Employee enrolls timely in the plan.

O As of the first day of the month after the date the employee satisfies eligibility requirements (for example, if the employee satisfies eligibility requirements on June 15, the effective date of coverage will be July 1).

O As of the first day of the month after the date the employee enrolls timely in the health benefit plan (for example, if the employee enrolls on June 15, the effective date of coverage will be July 1).

O Other _____.

14. Coverage of an employee and dependents who enroll because of a special enrollment event will be effective:

O As of the date the employee enrolls in the plan.

O As of the first day of the month after the date the employee timely enrolls (for example, if the employee gets married on June 15 and enrolls immediately, the effective date of coverage will be July 1; however, if the employee gets married on June 15 and timely enrolls on July 2, the effective date of coverage will be August 1).

O Other _____.

The coverage of an employee/dependent who enrolls because of a special enrollment event that is the birth, adoption or placement for adoption of a child or during open enrollment will be effective as stated in the plan document.

15. Coverage of an employee and dependents who enroll/disenrolll because of a change in status event will be effective:

O As of the date the employee submits his or her properly completed change in election form.

O As of the first day of the month after the employee submits his or her properly completed change in election form (for example, if the employee gets divorced on June 15 and submits a change of election form on June 18 to remove his or her former spouse from coverage, the effective date of the spouse's removal from coverage will be July 1; however, if the change in election form is submitted on July 2, the effective date of the spouse's removal from coverage will be August 1).

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

O Other _____.

The coverage of an employee/dependent who enrolls because of a special enrollment event that is the birth, adoption, or placement for adoption of a child or during open enrollment will be effective as stated in the plan document.

16. Change in Status Events (mid-year changes) will be allowed for the events as indicated by each check mark:

O Birth or Adoption of a Child

O Child No Longer Meets Health Benefit Plan Eligibility Requirements

O Loss of Coverage From Another Group Health Benefit Plan or Other Health Insurance

O Child Again Meets Health Benefit Plan Eligibility Requirements

O Marriage

- O Change in Spouse or Child Coverage Under Another Employer Health Benefit Plan
- O Divorce
- O Family Medical Leave
- O Death of Spouse or Child
- O A Change in Residence
- O HIPAA Special Enrollment Events
- O Loss of Certain Other Health Coverage
- O Change in Employment Status
- O Entitlement to Medicare or Medicaid
- O Significant Cost Changes
- O Judgments, Decrees and Orders
- O Significant Curtailment of Coverage

17. Annual reenrollment of election requirement:

- O Employees must complete a new election form in order to continue the pretax deduction for the health benefit plan premium
- O Allow employees to continue the pretax deduction without completing a new election form through the Evergreen rule provision. Applicable premium adjustments will be applied.

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

Having made the elections described in this Adoption Agreement, the employer hereby adopts the plan, which is hereby executed in its name and on its behalf by a duly authorized representative of the employer or his or her authorized agents.

Adopting Employer: _____ Title: _____

Completed by: _____ Date: _____

Witness Signature: _____ Date: _____

APPENDIX D

SAMPLE NOTICE TO EMPLOYEES

APPENDIX D
SAMPLE NOTICE TO EMPLOYEES

Your Premium Only Plan

The Section 125 Premium Only Plan helps you pay for Company-sponsored health benefit plan premiums with pretax dollars. You are eligible to participate if you meet the eligibility requirements described in your Section 125 Plan Document.

How it Works

After you enroll in Company-sponsored benefits (as an eligible new hire or during the annual enrollment period) you will have two choices:

1. **Elect to participate in the Premium Only Plan** and pay for your employer-sponsored health benefit plan premium before taxes are withheld. This reduces your taxable income, which also can increase your take-home pay, or

2. **Decline participation** and pay for your employer-sponsored health benefit plan premiums after taxes are withheld. This keeps all of your wages as taxable income.

You must complete a Pay Deduction/Enrollment Form and return it to [contact name or dept.] either within 30 calendar days from your date of hire or before the end of the annual enrollment period.

Your Premium Only Plan election is generally effective for an entire calendar year. Each year, you may change your election during open enrollment (effective the first day of the next calendar year). You may change your election during the year only if there is a qualifying life change event as described in the following sections.

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

Making Mid-Year Election Changes

IRS rules limit when Premium Only Plan changes can be made. You can change pretax deductions mid-year only if you have a qualifying life change event. You also may enroll if you experience a HIPAA Special Enrollment Event.

To make a mid-year election change, you must complete an Employee Change in Status Form within the timeframe stated in your Plan Document. You may be required to provide proof of any changes, such as a copy of a birth or marriage certificate. Contact [department or name and phone number] for details.

Qualifying Life Change Events

Your Plan allows you to make a mid-year Premium Only Plan election change if you experience one of these qualifying life change events:

[Employers: Work with your adviser to determine which events your plan will recognize; list those events here. Ensure that listed events correspond with events permitted under the health plan and events checked in the Adoption Agreement.]

In most situations, a mid-year change must correspond with the life change or event that prompts it. For example, you may drop an ex-spouse's coverage when you get divorced, but you cannot drop your own coverage.

HIPAA Special Enrollment Rights

The federal Health Insurance Portability and Accountability Act of 1996 allows a special opportunity for you to enroll in the Premium Only Plan as a result of:

- → Birth or adoption of a child
- → Loss of coverage from another group health benefit plan or other health insurance; this includes if you declined coverage for yourself, spouse or other dependent, or were covered by another health benefit plan, and then lost that coverage, but this does not apply if you or your dependent lost coverage because you stopped paying for it
- → Marriage
- → You or your dependent's loss of eligibility under Medicaid or a state children's health insurance program (SCHIP)
- → You or your dependent becoming eligible for a state premium assistance subsidy under Medicaid or SCHIP.

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See your Plan Document or contact [department or name and phone number] for more information.

Potential Impact on Other Benefits

Participation in the Premium Only Plan could impact other benefits that are based on your compensation. For example, if you choose the pretax option, your Social Security benefits may be slightly reduced. For more information, contact [contact name or dept.].

APPENDIX E

SAMPLE PAY DEDUCTION/ENROLLMENT FORM

APPENDIX E
SAMPLE PAY DEDUCTION/ENROLLMENT FORM

Employee Name: _____

Employee Social Security Number: _____

Employee ID #: _____

Plan Name: _____Section 125 Premium Only Plan_____

Plan Year: 20____ calendar year (or if not a calendar year: _____through_____)

As an eligible employee in the above Section 125 Premium Only Plan, I acknowledge that I have received the Notice to Employees. I have read the Notice to Employees and understand the benefits available to me as well as the other rights and obligations I have under the plan.

In accordance with my rights under the Plan, I elect as follows:

Election for Benefits

0 Pretax premium payment. On a separate enrollment form, I have enrolled for the health benefit plan specified on that form. I understand the contributions required for that health benefit plan, and I authorize a pretax deduction from my paycheck in the amount specified for the health benefit plan I have elected.

Waiver of Benefits (Election Not to Participate)

0 I understand all the benefit options available under the Plan and elect not to participate. I understand that if I have enrolled for a health benefit plan on a separate form, I will be required to pay the contributions required for that health benefit plan after taxes, and I authorize an after-tax deduction from my paycheck in the amount specified for the health benefit plan I have elected, if any.

Note: These Appendices are not intended to be used as is, but as a starting point, for review by legal counsel.

Other Terms and Conditions

I understand that:

- I cannot change or revoke any of my elections at any time during the plan year unless I have an approved mid-year change including:
  - Marriage
  - Divorce
  - Death of a spouse or child
  - Birth or adoption of a child
  - Change in my or my spouse's employment status
  - My spouse or I take an unpaid leave of absence
  - Change in health benefit coverage for my spouse or child under another employer health benefit plan, or
  - Other events as the Plan Administrator determines will permit a change or revocation of an election that is a permitted event under both this Plan and the health benefit plan
- The plan administrator may redirect or cancel my election or otherwise modify this agreement if advisable to satisfy certain Internal Revenue Code provisions.
- The pay deduction under this agreement will be in addition to any deductions under other agreements or benefit programs maintained by my employer.
- During a scheduled open enrollment period each year, I will be offered the opportunity to change my pay deduction election for the following plan year. If I do not complete and return a new election form at that time, I will be considered as having elected to continue this pay deduction agreement in the amount of the required contribution for the benefit option.
- If I choose the pretax option, my Social Security benefits may be slightly reduced. (If you have questions about your tax liability, please consult a qualified tax professional.)

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This agreement is subject to the terms of the Section 125 Plan in effect at the time of the election and as amended from time to time. The Plan will be governed by and administered in accordance with applicable laws. This election revokes any prior election and pay deduction agreement relating to the Plan.

Employee Name: _____

Signature: _____

Date: _____

APPENDIX F

EMPLOYEE CHANGE IN STATUS FORM

APPENDIX F
EMPLOYEE CHANGE OF STATUS FORM

1. Request for a Change in Election (complete A and/or B, as appropriate)

A) Effective_____, I wish to revoke my existing election under the [company] Section 125 Premium Only Plan. Type of coverage being revoked (my prior election for all other types of coverage remains in effect):

Health benefit plan coverage for (check all that apply):

O Myself

O Spouse

O Dependent(s) _____

B) Effective _____, I make a new election as specified on the attached Pay Deduction/Enrollment Form.

2. Reason for Change Request

Check box(es) to indicate the applicable event(s). Election changes generally cannot be retroactive and must be consistent with the change in election event.

Change in Life Status:

O Marriage

O Divorce or annulment

O Legal separation

O Death of spouse

O Birth

O Adoption or placement for adoption

O Lost eligibility under Medicaid or SCHIP

O Became eligible for premium subsidy under Medicaid or SCHIP

O Death of dependent

O Judgment, decree, or court order to cover a dependent

O Judgment, decree, or court order removing coverage requirement for dependent

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Change in Employment Status That Affects Eligibility:

	You	Your Spouse or Dependent
Termination of employment	0	0
Commencement of employment	0	0
Part-time to full-time	0	0
Full-time to part-time	0	0
Other Provide details in an attachment.	0	0

Change in Dependent's Eligibility Under an Employer's Health Benefit Plan

Lost eligibility	0
Gained eligibility	0

Change in Residence Affecting Eligibility

You	0
Your Spouse or Dependent	0

Other Event (see your Plan Document or Summary Plan Description for the list of other events that permit a change in election)

Provide details in an attachment.

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I understand that I may be required to provide proof of any changes I have checked above. Status and participation changes must comply with the health benefit plan, and the plan administrator has sole discretion to make this determination. I certify that such new, improved or court-ordered coverage has already been obtained or is in the process of being obtained for the applicable person for whom I am requesting an election change to cancel or reduce coverage because:

- → I or my family member has become eligible for new or improved health benefit plan coverage (including coverage at a reduced cost) under an employer's plan or has become entitled to Medicare/Medicaid, or

- → A judgment, decree or order requires an individual other than me to provide accident or health coverage for my child.

If my change in election is denied, I understand I will have to appeal the decision within the time frame specified in the Plan Document. If approved, I elect the change(s) noted on the attached Pay Deduction/Enrollment Form and attest that the change is made on account of and is consistent with the change in election event.

_____ _____

Employee's Signature Date

Accepted and agreed to:

_____ _____

Plan Administrator's Signature Date

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